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Note

ECONOMIC CREDENTIALING: YOUR MONEY OR YOUR LIFE!

The economic overhaul of health care in America is restructuring the business of medicine, and with it the relationship between physician and patient. Previously accustomed to thinking primarily about the best interests of each patient, the physician now finds this traditional loyalty in conflict with competing concerns, including those of government, business, and insurers who watch with alarm the relentless rise in their health care expenditures. And there are competing interests of hospitals, health maintenance organizations, and other provider-institutions who find their survival threatened by high-powered competition and increasingly stringent resource limits, and interests of other physicians and their patients whose health needs compete for limited health care dollars.¹

I. INTRODUCTION

A HEART SURGEON at County Memorial Hospital recently had her hospital privileges² revoked by the hospital board. Revocation came after a routine peer review³ by the hospital's medical staff. As a practicing physician at County Memorial, this surgeon maintained a stellar success rate, her quality of care was impeccable, her competence was unquestioned, and

1. E. Haavi Morreim, *Economic Disclosure And Economic Advocacy: New Duties in The Medical Standard of Care*, 12 J. LEGAL MED. 275, 275 (1991).

2. Hospital privileges (also known as clinical privileges) are defined as "[p]ermission to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license and his/her experience, competence, ability, and judgment." Joint Comm'n on Accreditation of Healthcare Orgs., *THE ACCREDITATION MANUAL FOR HOSPITALS* 53 (1993) [hereinafter JCAHO MANUAL]. Physicians must have such privileges in order to use the beds, equipment and support staff within the facility. *Id.*

3. Peer review (also known as credentialing) is where "[t]he organization establishes hospital-specific mechanisms for the appointment and reappointment of medical staff members and the granting and renewal/revision of clinical privileges." *Id.*

her patients liked her. However, she had one problem: she did not sufficiently contribute to the bottom line of the hospital.⁴ In other words, the hospital decided that she was not making enough money for the hospital, and for that reason alone, she is no longer permitted to admit patients there.⁵

Due to the current rising costs of health care, the practice of medicine is undergoing an economic overhaul.⁶ The economic difficulties which hospitals are experiencing are evidenced by the fact that between 1980 and 1989, low profits and high competition led to the closure of nearly 700 hospitals in this country.⁷ These economic troubles have forced hospitals to behave more like businesses⁸ and less like the charitable institutions they once were.⁹

Furthermore, hospitals are being held liable for the wrongdoings that occur within their facilities.¹⁰ This liability has led to the creation of the medical staff peer review process to ensure the quality and competence of the physicians practicing in a hospital. Through peer reviews, physicians are reviewed based on various criteria to determine whether or not they will be allowed privileges to admit and treat their patients in the hospital. In order for a hospital to relieve itself of malpractice liability, it enforces these peer review decisions to prevent incompetent physicians from obtaining privileges.

4. There are a number of ways a physician negatively may affect the bottom line. Her procedures may cost more than the Diagnostic Related Group ("DRG") payment will reimburse, she may have many Medicaid patients who typically are not as profitable as other patients, or she may be competing with the particular hospital by also treating patients at another hospital. See *infra* notes 85-106 and accompanying text.

5. This scenario could have been painted differently. Rather than having her current privileges reviewed for renewal, the surgeon could have been attempting to obtain privileges from the hospital for the first time. The same medical staff could have reviewed her and decided that, although there is no question as to the quality of care this physician would provide, she might not be the most profitable physician for the hospital.

6. See Morreim, *supra* note 1, at 275.

7. John D. Blum, *Hospital-Medical Staff Relations in The Face of Shifting Institutional Business Strategies: A Legal Analysis*, 14 PUGET SOUND L. REV. 561, 561 (1991).

8. Morreim, *supra* note 1, at 275.

9. See ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY 17 (1989) (noting that the hospitals of today grew out of public and private welfare institutions for the poor of the nineteenth century).

10. *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253, 258 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966) (holding that a hospital may be held independently liable for negligently failing to monitor the quality and competence of the physicians on its staff).

Since the primary focus of the peer review process always has been on the quality of care, recent attempts to define a physician's qualifications for hospital privileges based on economic factors unrelated to quality of care or competency considerations, known as "economic credentialing," have been met with substantial controversy.¹¹ While economic credentialing considers the financial impact a physician has on the hospital, it completely disregards the competence, skill and quality of the physician's work. Under a policy of economic credentialing, a physician could be excluded for treating too many poor patients, for having privileges in a competing hospital, or for simply providing complete and effective care. Although the hospital may have a financial rationale for such a policy, economic credentialing ignores and interferes with the public's interest.

Although courts generally have upheld adverse peer review decisions based on quality or competence concerns, whether a court would uphold a peer review decision based solely on economic considerations is uncertain.¹² As economic credentialing has posed the latest threat to physicians receiving and renewing their hospital privileges, it is sure to receive its share of litigation in the future. These economic factors will add fuel to the fire in the already volatile arena of physicians suing hospitals for the denial or revocation of hospital privileges.

11. See, e.g., Jay Greene, *Hospitals Eyeing Physicians' Practice Patterns: Economic Credentialing Is Being Tested To Reduce Expenses And Improve Quality*, MODERN HEALTHCARE, Apr. 29, 1991, at 30, 30 ("[S]ome physicians and experts contend economic credentialing can lead to poor patient care by limiting services, reducing access to care and interfering with the physician-patient relationship."); Mary T. Koska, *Hospital CEOs Divided on Use of Economic Credentialing of Physicians*, HOSPITALS, Mar. 20, 1991, at 42, 42 (describing the policy at Haverford Memorial Hospital in which the hospital has "no qualms about completely terminating [the physician's] hospital privileges if his financial performance failed to improve."); Howard L. Lang, M.D., *Curb Economic Credentialing*, MODERN HEALTHCARE, Apr. 29, 1991, at 28, 28 ("To enable physicians to continue to advocate in the patient's interest, subversion of quality patient care to economic motivations must be stopped."); Commentary, *Credentialing is a Fact of Life*, MODERN HEALTHCARE, June 17, 1991, at 36, 36 ("Economic credentialing is a fact of life, and it will serve in the future to bond more closely the physician and the hospital.").

12. As of the date of this writing, only one court in the country has ruled explicitly on economic credentialing. See *Rosenblum v. Tallahassee Memorial Regional Med. Ctr.*, No. 91-589 (Cir. Ct. Leon County, Fla. filed June 22, 1992) (holding the denial of privileges to a physician based solely on economic considerations is valid based on an interpretation of a Florida statute). This case is of limited value, however, as the physician was planning to appeal the decision but never did because the hospital eventually granted him privileges.

This note argues that hospitals should not be allowed to use economic credentialing in evaluating physicians because, by ignoring quality and competency concerns, it goes against the grain of public policy and unreasonably interferes with legitimate health care objectives. Furthermore, as disgruntled physicians have challenged adverse peer review decisions with some success, based on breach of hospital bylaws or antitrust violations, economic credentialing will give physicians a stronger argument when attacking adverse peer reviews on these grounds.

Part II of this note discusses the hospital/physician relationship, explains the peer review credentialing process, and provides a definition of economic credentialing. Part III analyzes how hospital policies, such as economic credentialing, have a significant impact on society and should be implemented only in the public's interest. Finally, Part III analyzes how adverse peer review decisions have been handled by the courts when challenged by physicians and concludes that these challenges can be utilized to invalidate peer review decisions that use economic credentialing.

II. BACKGROUND

A. The Hospital Structure

A hospital is described as a "three-legged stool" consisting of the administration, the governing board, and the medical staff.¹³ The hospital administration consists of salaried employees who are responsible for the day-to-day operations of the hospital.¹⁴ The hospital administration provides "nonphysician patient care," such as nursing and operating rooms, and other "institutional support services," such as accounting and data processing.¹⁵

13. STEVENS, *supra* note 9, at 241 (identifying the three primary power structures within the hospital and noting the current difficulty in drawing lines between a hospital's business and medical functions); Blum, *supra* note 7, at 563. However, in spite of the recent economic changes that have forced hospitals to be more concerned with business issues, the basic structure of the hospital remains unchanged. *Id.*

14. John J. Miles & Mary S. Philp, *Hospitals Caught in the Antitrust Net: An Overview*, 24 DUQ. L. REV. 489, 501 (1985). For a more detailed list of the duties of the hospital administrator, see JCAHO MANUAL, *supra* note 2, at 41-44.

15. Thaddeus J. Nodzenski, *Where Is The Quality in The Health Care Quality Improvement Act of 1986?*, 22 LOY. U. CHI. L.J. 361, 380 (1991). Hospital administrators are barred from admitting patients or providing other patient services without prior physician consent. *Id.* at 379. Furthermore, while the hospital bylaws delegate some authority to the

The governing board, consisting of the board of trustees and governors, has the ultimate decision making authority in the hospital.¹⁶ It is important to realize, however, that although the board has the ultimate authority it rarely exercises it.¹⁷ In fact, the board typically acts as a "rubber stamp," usually deferring to the medical staff and approving their decisions.¹⁸

The medical staff consists of the physicians who have been issued privileges to admit their patients to the hospital for treatment.¹⁹ In return for these privileges, physicians have various responsibilities to the hospital, such as following the hospital bylaws and serving on various committees.²⁰ One of the most important of these responsibilities is participating in the peer review process.²¹

B. The Peer Review Process

A physician may not simply take a patient, walk into a hospital, and begin operating. The right of a physician to admit patients to a hospital for treatment is known as hospital privileges.²² Privileges are crucial to most physicians because physicians need the beds, equipment, staff, and supplies of a hospital in order to effectively treat their patients.²³ The process by which the hospital determines which physicians will receive these privileges is known as credentialing or peer review.²⁴

During physician credentialing, the members of the committee must decide whether to issue or renew hospital privileges

hospital administration, it is not authorized to supervise the manner in which physicians treat their patients. *Id.* at 380.

16. John D. Blum, *Economic Credentialing: A New Twist In Hospital Appraisal Processes*, 12 J. LEGAL MED. 427, 459 (1991).

17. STEVENS, *supra* note 9, at 244-45 (emphasizing that, although boards of trustees have the legal right to dictate medical policy, they usually defer to others).

18. *Id.* (recognizing that decisions about new members of the medical staff are normally based upon the recommendations of medical staff committees).

19. Miles & Philp, *supra* note 14, at 501-02 (discussing hospital organization and staff credentialing). See also JCAHO MANUAL, *supra* note 2, at 53 ("All [medical staff] members have delineated clinical privileges that allow them to provide patient care services independently within the scope of their clinical privileges.").

20. Miles & Philp, *supra* note 14, at 501. For a more detailed list of the duties and responsibilities of the medical staff, see the JCAHO MANUAL, *supra* note 2, at 53-73.

21. Miles & Philp, *supra* note 14, at 501.

22. See JCAHO MANUAL, *supra* note 2.

23. Nodzenski, *supra* note 15, at 378 (discussing access to hospital resources as essential to physician's ability to practice medicine).

24. See JCAHO MANUAL, *supra* note 2.

to the physician under review.²⁵ This decision is based on a variety of factors such as the physician's competence, ability, experience and judgment.²⁶ Any physician who is applying for privileges for the first time to a particular hospital will undergo such a review.²⁷ Furthermore, hospitals will submit physicians currently holding privileges to the same review in order to assure that all their physicians are competent and are providing high quality care.²⁸ Although the board has the final word on any credentialing decision, most often they defer to the medical staff's decision.²⁹ The board's responsibilities to the credentialing of physicians, as well as other responsibilities, are illustrated in statutes³⁰ and common law,³¹ as well as the accreditation regulations of the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").³²

25. *Id.* at 53.

26. *Id.*

27. Miles & Philp, *supra* note 14, at 502.

28. Since the granting or renewal of privileges are made for no more than two years, a physician must have his/her current privileges reviewed every two years to maintain them. JCAHO MANUAL, *supra* note 2, at 56.

29. See STEVENS, *supra* note 9, at 244-45 (explaining that decisions about new members of medical staff normally are based upon the recommendations of medical staff committees).

30. For example, under California law the board is expressly given the final credentialing authority. CAL. CODE REGS. tit. 22, § 70701(a)(1)(A)-(F) (1991). Furthermore, Illinois state law charges the board with the responsibility for the hospital organization, management, control, operations, and appointment of the medical staff. ILL. ANN STAT ch. 210, para. 85/10 (Smith-Hurd 1990).

31. Most courts have held the governing board responsible "to evaluate, counsel, and if necessary take action to prevent unreasonable risk of harm by physicians to patients treated in their facilities." James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, 51 LAW & CONTEMP. PROBS., Spring 1988, at 7, 17. The idea that hospitals are responsible for the quality of care provided under their roof is known as hospital corporate liability. *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966). This liability imposes a legal duty upon the hospital to engage in the effective credentialing of its physicians. Blum, *supra* note 16, at 461. The role of the governing board has also been characterized as that of a fiduciary of the public. *Id.* See also *Desai v. St. Barnabas Med. Ctr.*, 510 A.2d 662, 668 (N.J. 1986) (stating that hospital powers that relate to the quality of care must be exercised reasonably for the public good and must serve public health objectives).

32. Under the JCAHO standards, the authority to make the final credentialing decision rests with the board. JCAHO MANUAL, *supra* note 2, at 26. The board must act in a timely manner to the recommendations of the medical staff. *Id.* If there is a dispute between the board and the medical staff, JCAHO standards require a joint conference to resolve the issue in a timely manner. *Id.* The JCAHO standards are implemented in medical staff bylaws which are binding on the hospital. *Id.* at 58. For further explanation of the functions of JCAHO, see *infra* notes 41-43, 71-78 and accompanying text.

The result of the peer review may be a positive one; the physician under review may obtain new privileges or have existing privileges renewed. On the other hand, the decision may be an adverse one; the physician may be denied new privileges or have existing privileges revoked. As would be expected, those disgruntled physicians who receive adverse peer reviews turn to the courts for redress. The following sections will discuss the rationale for the peer review system and how peer reviews have been implemented.

1. The Development of The Medical Staff Peer Review Process

Today's system of medical staff peer review has evolved as the relationships between physicians and hospitals have changed.³³ In the early twentieth century, hospitals were almshouses for the poor while wealthier patients were treated by private physicians in the comfort of their homes.³⁴ However, with the growing concept of surgery in hospitals, physicians' interest in gaining access to these hospitals also grew.³⁵

Momentum for hospital reform came about in the early part of the 20th century with the development of state medical boards of licensure and improved medical education.³⁶ After a survey from the American College of Surgeons ("ACS")³⁷ revealed substantial deficiencies in hospitals, the ACS established a set of national standards for hospital accreditation.³⁸ The ACS required that physicians affiliated with hospitals must organize into a medical staff³⁹ and that "medical staff member-

33. Blumstein & Sloan, *supra* note 31, at 10.

34. See STEVENS, *supra* note 9, at 17-51 (discussing the public's initial resistance to hospitalization and how wealthy patients were attracted by offering luxurious amenities in the early twentieth century).

35. *Id.* at 34 (linking an increase in physicians interest in hospitals to the general acceptance of the germ theory).

36. Blum, *supra* note 16, at 431.

37. By the 1920's, the ACS had emerged as a private organization which attempted to establish voluntary ethics standards for hospitals. STEVENS, *supra* note 9, at 114. If a hospital conformed to the ACS standards it was certified; this was similar to a "Good Housekeeping Seal of Approval," in that it assured consumers that they could expect a certain level of quality and standardization. *Id.*

38. *Id.* at 114-15 (after inspecting hospitals with over 100 beds, the ACS found that less than one-seventh met its minimal standards).

39. *Id.* at 114 (organizing the doctors into a medical staff facilitated the implementation of the ACS standards).

ship must be restricted to doctors competent in their fields and worthy in character."⁴⁰

In 1952, the Joint Commission on Accreditation of Hospitals was created collectively by the ACS, the American Medical Association, and others. After initially adopting the standards created by the ACS,⁴¹ JCAHO eventually expanded the requirements for medical staff peer review that were necessary for hospital accreditation.⁴² As JCAHO has refined its standards over time, it has dominated the shaping of hospital medical staffs and the development of physician credentialing requirements.⁴³

2. The Implementation of The Peer Review Process

Several rationales have been proposed for the development of the peer review process. Some take a paternalistic view, asserting that "[s]ince the medical field is so specialized, only physicians can protect patients from poor-quality medical care."⁴⁴ Others believe that the medical staff functions like *Consumer Reports*, providing necessary consumer information to the patients.⁴⁵ Medical staff reviews also are seen as a means to control the utilization of medical services while internally monitoring the quality of care.⁴⁶ Whatever the rationale, the peer review process has been adopted as the process through which accredited hospitals issue and renew privileges to physicians. Indeed, common law, federal statutes, state statutes,

40. Blum, *supra* note 16, at 431-32.

41. STEVENS, *supra* note 9, at 247. JCAH (now JCAHO) was a private, not-for-profit organization that became the only organization concerned with hospital standardization. *Id.* There is no clear history of the establishment of JCAH. *Id.* at 247 n.49. Like the ACS, compliance with JCAH's regulations was voluntary. *Id.* at 248. Although this accreditation system was (and still is) voluntary, it was a stable system that became an accepted bureaucratic process. *Id.*

42. *Id.* (creating and then revising hospital bylaws, JCAH modified the peer review process relating to the granting and withdrawing of privileges); Blumstein & Sloan, *supra* note 31, at 10. JCAHO accreditation is important to hospitals because several states mandate it, and under certain circumstances, accredited hospitals may be automatically eligible for Medicare reimbursements. *Id.* at 11. Since accreditation is so important to hospitals, the JCAHO standards for medical staff review are taken very seriously. *Id.*

43. Timothy S. Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care And The Public Interest*, 24 B.C. L. REV. 835, 872-74 (1983).

44. Blumstein & Sloan, *supra* note 31, at 12.

45. *Id.* at 13.

46. *See id.* at 12-13 (reviewing the battle between quality assurance of care versus the conflict of interest with cost).

JCAHO regulations, and medical staff bylaws all have a hand in the implementation of the peer review process.

Common Law: At one time, the perception was that hospitals did not act through their physicians, but rather that they procured physicians who were responsible for their own actions.⁴⁷ Under this view, the hospitals were not legally responsible for their physicians' torts. However, in the landmark ruling of *Darling v. Charlestown Community Hospital*,⁴⁸ the Supreme Court of Illinois established that a hospital may be held independently liable for negligently failing to monitor the quality and competence of the physicians on its staff.⁴⁹ The *Darling* court stated,

Certainly the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that the nurses or other employees will act on their own responsibility. The Standards for Hospital Accreditation, the state licensing regulations and the [hospital's] bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patients.⁵⁰

It was at this juncture that the common law first recognized that hospitals could be held responsible for torts under a theory of corporate liability.

Similarly, in *Johnson v. Misericordia Community Hospital*⁵¹ the Supreme Court of Wisconsin further defined the hospital's duty. In *Johnson*, the court held that "a hospital owes a duty to its patients to exercise reasonable care in the selection of its medical staff and in granting specialized privileges."⁵² Here, the court specifically stated that this is to be accomplished via the peer review process by investigating the physician's competence, education, training, experience, adverse malpractice actions, and by determining whether the physician

47. *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) *cert. denied*, 383 U.S. 946 (1966) (quoting *Bing v. Thunig*, 143 N.E.2d 3, 8 (N.Y. 1957)).

48. 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).

49. *Id.* at 258.

50. *Id.* at 257 (quoting *Bing*, 143 N.E.2d at 8).

51. 301 N.W.2d 156 (Wis. 1981) (asserting duty of hospital to exercise reasonable care in medical staff privileging and selection).

52. *Id.* at 174.

has lost privileges in any other hospital.⁵³ Therefore, the *Johnson* court made it clear that the objective of the peer review is to insure a high quality of care in the hospital and failure to use the peer review process to insure such quality may result in liability to the hospital.⁵⁴

Federal Statute: In attempting to deal with the medical malpractice crisis, Congress enacted the Health Care Quality Improvement Act of 1986 ("HCQIA").⁵⁵ The Act establishes a two part program by which the medical profession can rid itself of unsatisfactory physicians by: (1) providing limited immunity from legal liability for physicians who engage in good-faith peer review activity⁵⁶ and (2) establishing a national data bank for reporting physicians' acts of incompetence and malpractice.⁵⁷

Although Congress stated that the peer review system is critical in solving the medical malpractice crisis,⁵⁸ it realized that the peer review system could be used as a ploy to eliminate the competition of perfectly good physicians.⁵⁹ Courts and commentators have grappled with this dilemma in attempting to distinguish good faith peer reviewers from those who are oper-

53. *Id.* (stressing that the credentialing committee does not relieve the hospital of its duty to evaluate, monitor and admit only competent physicians).

54. Although not all state courts have held hospitals corporately liable for implementing the peer review process, the trend is sufficiently strong and sufficient to lead one to conclude that under common law such peer reviews are legally mandated. *See, e.g., Bell v. Sharp Cabrillo Hosp.*, 260 Cal. Rptr. 886, 897 (Cal. Ct. App. 1989) (holding that a hospital is negligent if it doesn't exercise reasonable care in selecting and reviewing the competency of its staff physicians); *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156, 165 (Cal. Ct. App. 1982) (holding a hospital corporately liable for insuring the competency of its medical staff); *Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989) (holding that the doctrine of corporate negligence imposes a duty upon a hospital to select and retain competent physicians through the issuance of staff privileges); *Pedroza v. Bryant*, 677 P.2d 166, 170 (Wash. 1984) (holding the doctrine of corporate liability applicable to impose a duty on a hospital to grant privileges only to competent physicians).

55. 42 U.S.C. §§ 11101-11152 (1988).

56. 42 U.S.C. §§ 11111-11115.

57. 42 U.S.C. §§ 11131-11137.

58. *See* 42 U.S.C. § 11101. ("The increasing occurrence of medical malpractice and the need to improve the quality of medical care . . . can be remedied through effective professional peer review."). *See also* Charity Scott, *Medical Peer Review, Antitrust, and the Effect of Statutory Reform*, 50 MD. L. REV. 316, 323 n.24 (1991) ("limiting the potential legal liability of peer-review participants will result in more candid deliberation and effective outcomes and improved quality of medical care").

59. Scott, *supra* note 58, at 329 n.54 ("[I]t is likely that the [peer review] process will be abused for anticompetitive or antisocial purposes . . .").

ating in their own economic best interests.⁶⁰ The HCQIA is Congress' attempt to improve the quality of medical care by encouraging and protecting the proper use of the peer review system.⁶¹

The HCQIA grants antitrust immunity to physicians who participate in good-faith peer review attempts to weed out incompetent physicians.⁶² Congress specifically stated that immunity will be provided to physicians who participate in peer review activity based on "the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients)."⁶³ Congress specifically excluded immunity for "any other matter that does not relate to the competence or professional conduct of a physician."⁶⁴ Therefore, in enacting the HCQIA, Congress was anticipating that the peer review process would be implemented effectively for maintaining quality health care and competent physicians.⁶⁵

60. See, e.g., Miles & Philp, *supra* note 14, at 505 ("Ways must be sought to weed out meritless cases early on, but without doing injustice to appropriate principles of antitrust jurisprudence.").

61. But see Scott, *supra* note 58, at 321-22 ("[T]he statutory reform effected by the Act falls short of that heralded by its supporters, and . . . because the Act does not change the substantive rules governing antitrust liability in peer review cases, its much-touted 'immunity' is more imaginary than real.").

62. See 42 U.S.C. § 11111(a) (1988) (stating that anyone involved in the peer review process "shall not be liable in damages under the law of the United States or of any State . . . with respect to the action" so long as it meets the good faith standards of § 11112(a)). See also *Decker v. IHC Hosps., Inc.*, 982 F.2d 433, 436 (10th Cir. 1992) (concluding that the "HCQIA establishes immunity from liability" only, not immunity from the suit); *Austin v. McNamara*, 979 F.2d 728, 737 (9th Cir. 1991) (holding that the HCQIA immunized the hospital and its physicians from antitrust liability for suspending a neurosurgeon's privileges because the peer review was based on quality concerns); *Smith v. Ricks*, 798 F. Supp. 605, 610 (N.D. Cal. 1992) ("In order to prove that the review actions . . . were taken in the reasonable belief that they were in furtherance of quality health care, Defendants must show that 'with the information available to them at the time of the professional review action, [Defendants] would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.'" (quoting *Austin v. McNamara*, 731 F. Supp. 934, 940 (C.D. Cal. 1990))); *Fobbs v. Holy Cross Health Sys. Corp.*, 789 F. Supp. 1054, 1065 (E.D. Cal. 1992) ("The HCQIA provides immunity for discrete professional review actions/decisions which meet particular standards, i.e., reasonable belief that the action furthered quality health care . . ."); Scott, *supra* note 58, at 331 & n.62 (the immunity provisions of the Act were redrafted "to protect physicians who participate in a good-faith effort to weed out their incompetent colleagues . . .").

63. 42 U.S.C. § 11151(9) (1988).

64. 42 U.S.C. § 11151(9)(E).

65. In order to be protected, the peer review must be:

(1) in the reasonable belief that the action was in the furtherance of quality health care,

State Statutes: While most state statutes institute requirements for the hospital peer review process,⁶⁶ there is a split as to the specificity of the requirements. Some statutes only serve as a broad framework in which hospitals should implement the peer review process.⁶⁷ For example, Illinois law allows generally flexible credentialing requirements that are consistent with the institution's objectives.⁶⁸ On the other hand, some states have more detailed requirements.⁶⁹ For example, Maryland law considers that the credentialing process reviews the physician's education, clinical expertise, licensure history, medical history,

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- (2) after a reasonable effort to obtain the facts of the matter,
 - (3) after adequate notice and hearing procedures are afforded . . . , and
 - (4) in the reasonable belief that the action was warranted by the facts known

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in Section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

42 U.S.C § 11112(a) (1988).

66. See, e.g., CONN. GEN. STAT. ANN. § 19a-17b (West Supp. 1993); FLA STAT ANN. § 395.0193 (West 1993); GA. CODE ANN. § 31-7-15 (Michie 1992); HAW REV STAT. § 624-25.5 (1993); MASS. GEN. LAWS ANN. ch. 11 § 203 (West 1993); MO ANN STAT. § 537.035 (Vernon 1988); OR. REV. STAT. § 441.055 (1991); TX CIV STAT ANN art. 4495b (West 1994).

67. See, e.g., MASS. GEN. LAWS ANN. ch. 111 § 203(a) (West 1993) ("The by-laws of every licensed hospital and the by-laws of all medical staffs shall contain provisions for reporting conduct by a health care provider that indicates incompetency in his specialty or conduct that might be inconsistent with or harmful to good patient care or safety."); MO ANN. STAT. § 537.035(1)-(2) (Vernon 1988) (the responsibility of the peer review committee is responsible "to evaluate, maintain, or monitor the quality and utilization of health care services or to exercise any combination of such responsibilities."); OR. REV STAT § 441.055 (3)(d) (1991) ("The governing body shall: [i]nsure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the professional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care.").

68. ILL. ANN. STAT. ch. 210, para. 85/10.4 (Smith-Hurd 1993) (providing that, prior to renewing a staff member's privileges, a hospital must request information from the state concerning the staff member's licensure status and any disciplinary action taken against the staff member).

69. See FLA. STAT. ANN. § 395.0193 (3)(a)-(g) (West 1993) (requiring that the peer review committee find incompetence, habitual drug use, mental or physical impairment, medical malpractice, large malpractice settlements, or failure to follow hospital procedures, before altering a physician's privileges); GA. CODE ANN. § 31-7-15 (a)(1)-(3) (Michie 1992) (requiring peer reviews to include the "quality of the care provided," review of "diagnostic and surgical procedures," and the physician's "qualifications and professional competence"); TX. REV. CIV. STAT. ANN. art. 4495b § 103(9)(A)-(E) (West 1994) (requiring the peer review committee to evaluate "the qualifications of professional health care practitioners," specifically including evaluation of "accuracy of diagnosis," "quality of the care rendered," "reports made to a medical peer review committee," and "reports made by a medical peer review committee to others").

claims history and professional experience.⁷⁰ However, regardless of specificity, states tend to require that the peer review process be based upon some notions of quality and competence.

JCAHO Regulations: The standards of the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") for the peer review process are very specific.⁷¹ For example, they state that although the governing board has the final authority on credentialing decisions, the actual decisionmaking function is conducted by the medical staff.⁷² Furthermore, JCAHO requires that the medical staff maintain a set of bylaws that includes their rules for self governance.⁷³ JCAHO also mandates that each staff member is to have privileges appointed to him or her⁷⁴ and that these privileges are to be awarded via a specific peer review process as included in the bylaws.⁷⁵ Finally, JCAHO requires that physicians have their privileges reviewed every two years by this peer review process.⁷⁶ Although these standards are of a voluntary organization, arguably they have

70. MD. CODE ANN. HEALTH-GEN. § 19-319(e)(1) & (2)(i) (1990). Furthermore, Maryland specifically requires that the reappointment process is to be done every two years to review the physician's pattern of performance, utilization, quality and risk data. *Id.* at § 19-319(e)(2)(ii) & (iii).

71. See JCAHO MANUAL, *supra* note 2.

72. "The governing body is responsible for the final decision, based on medical staff recommendations, regarding an individual's appointment or reappointment to the medical staff and granting of initial or renewed/revised clinical privileges." *Id.* at 56. For the complete list of regulations relating to the medical staff's responsibilities, see *id.* at 53-73.

73. "The medical staff develops and adopts bylaws and rules and regulations to establish a framework for self-governance of medical staff activities and accountability to the governing body." *Id.* at 58.

74. "All its members have delineated clinical privileges that allow them to provide patient care services independently within the scope of their clinical privileges." *Id.* at 53.

75. "Medical staff membership and delineated clinical privileges are granted by the governing body, based on medical staff recommendations, in accordance with the bylaws, rules and regulations, and policies of the medical staff and of the hospital." *Id.*

Although the guidelines allow factors such as geography of the applicant, malpractice insurance coverage, and necessity of institutional resources to be considered, JCAHO requires the medical staff to primarily focus on clinical qualification. "The criteria are designed to assure the medical staff and governing body that patients will receive quality care." *Id.* at 54. "The criteria pertain to, at the least, evidence of current licensure, relevant training and/or experience, current competence, and health status." *Id.* "Board certification is an excellent benchmark and is considered when delineating clinical privileges." *Id.* at 56.

76. "Appointment or reappointment to the medical staff and the granting or renewal/revision of clinical privileges are made for a period of not more than two years." *Id.* at 56. These reviews require an evaluation of the physician's "professional performance . . . judgment and . . . clinical and/or technical skills . . ." *Id.* at 55.

the force of law.⁷⁷ Thus, JCAHO requirements have greatly affected the way hospitals run their peer review systems.⁷⁸

Medical Staff Bylaws: Like the JCAHO regulations, state law also requires the bylaws to include the rules for the peer review process.⁷⁹ Since medical staff bylaws constitute a contract between the medical staff and the hospital, both parties must follow the peer review rules and neither side unilaterally can change them.⁸⁰ Therefore, the bylaws will force the medical staff to abide by the rules in carrying out physician peer reviews.

In summary, the state and federal laws, in addition to the JCAHO regulations, set the standards for which hospital peer review will be implemented. These rules and regulations are given life through the hospital and medical staff bylaws. As evidenced by these rules, the chief factor of evaluation under the peer review system is quality of care. Since the bylaws are seen as a contract that cannot be unilaterally altered, an attempt to change the criteria of the peer review would prove difficult.

C. Economic Credentialing Defined

As noted above, the peer review credentialing process evaluates physicians based on quality and competence factors to ensure that the highest level of care is being provided in the

77. For example, the federal government relies on JCAHO accreditation when certifying hospitals to participate in the Medicare program. Jost, *supra* note 43, at 843. Furthermore, many states have included JCAHO accreditation decisions into their programs for licensing hospitals. *Id.* at 844. Finally, some private institutions, such as Blue Cross, have required JCAHO accreditation to participate in their programs. *Id.* at 845.

78. See STEVENS, *supra* note 9, at 248-49 (describing how JCAHO has provided the framework for establishing hospital peer review procedures).

79. See, e.g., CONN. GEN. STAT. ANN. § 19a-17b (a)(iv) (West Supp. 1993) (declaring "[m]edical review committee shall include . . . a committee of any health care institution established pursuant to written bylaws . . . engaging in peer review, to gather and review information relating to the care and treatment of patients . . ."); HAW. REV. STAT. § 624-25.5(a)(2) (1993) (function of the peer review committee is "to maintain the professional standards established by the bylaws of the society, hospital, or clinic of the persons engaged in its . . . hospital or clinic"); OR. REV. STAT. § 441.055(4)(e) (1991) ("The bylaws shall include . . . [p]rocedures for insuring that the facility's procedures for granting, restricting and terminating privileges are followed . . .").

80. "Each applicant for medical staff membership is oriented to these bylaws, rules and regulations, and policies and agrees in writing that his/her activities as a member of the medical staff will be bound by them." JCAHO MANUAL, *supra* note 2, at 53. "Neither body [the medical staff nor the governing board] may unilaterally amend the medical staff bylaws." *Id.* at 58.

hospitals.⁸¹ However, when the hospital reviews a physician and bases its privileging decision upon economic factors⁸² rather than the preferred quality and competency criteria, the hospital is using economic credentialing. The two key elements necessary to identify economic credentialing are: (1) a physician under review is only judged by economic criteria; and (2) this economic criteria is the only factor directly tied to the decision of whether or not to issue or renew the physician's privileges.⁸³ Economic credentialing "has nothing to do with professional quality and competence."⁸⁴

For a better understanding, the following are three illustrations of economic credentialing in action. Although these illustrations may seem different, all three are examples of economic credentialing being applied to prevent a physician from obtaining privileges in a particular hospital.

81. See Lang, *supra* note 11, at 28 ("The credentialing process, as performed by the medical staff, ensures the training and competence of the practitioners on the medical staff.").

82. For example, issuing privileges to a physician who has a more profitable patient-mix, or who does not have privileges in any competing hospital, or whose costs are lower so as to make more money for the hospital — may occur regardless of how competent the physician is. With economic credentialing, a top-quality, competent physician may be denied privileges simply for not bringing in as much money for the hospital as other physicians.

83. See Jay Greene, *System Pioneers Credentialing*, MODERN HEALTHCARE, Apr. 29, 1991, at 32, 32 (discussing the policies of two hospitals that review physicians solely on economic factors and tie that review to the credentialing decision).

84. Lang, *supra* note 11, at 28. A similar, but distinctly different practice is used by some hospitals that monitor physicians' practice patterns to pinpoint inefficient uses of resources. Greene, *supra* note 11, at 30. This practice, known as "Utilization Review (UR)", is a cost containment effort and quality assurance strategy implemented . . . to ensure that the services provided are both necessary and cost-efficient." Cheralyn E. Schessler, *Liability Implications of Utilization Review as a Cost Containment Mechanism*, 8 J. CONTEMP. HEALTH L. & POL'Y 379, 380 (1992). See also Lang, *supra* note 11, at 28 ("Utilization review seeks to avoid the provision of unnecessary services based on quality considerations, including services provided without good cause when less expensive alternatives would suffice as determined by professional judgment."). Such programs are used in hospitals to reduce expenses while improving the quality of care. Greene, *supra* note 11, at 30.

The distinct difference between UR and economic credentialing is that UR is a quality issue — not an economic issue. *Id.* "Overutilization, underutilization and inappropriate utilization do not represent good-quality care" *Id.* Furthermore, UR is not attached to the credentialing and decredentialing of physicians. *Id.* However, in one instance economic credentialing is directly tied to the credentialing and decredentialing of physicians and is not related to quality of care issues. Koska, *supra* note 11, at 42. Physicians are not worried about the use of economic criteria that may flag quality problems; they are concerned about economic criteria — unrelated to quality — being used in privileging decisions. *Id.* at 46.

1. Economic Credentialing to Maximize DRG Payments

With the current prospective payment system for reimbursement of hospital services (based on a system of Diagnosis Related Groups, or "DRGs"), physicians and hospitals are faced with competing incentives for providing health care. Under the DRG system, the hospital is reimbursed a set fee for each patient admitted — each patient being entitled to one diagnosis.⁸⁵ The diagnosis is determined after the patient is treated and released from the hospital, thus with the benefit of 20/20 hindsight.⁸⁶ Regardless of how expensive the patient was to treat or how long the patient spent in the hospital, the hospital receives only the fixed DRG payment.⁸⁷ Therefore, hospitals have an incentive to keep costs down.

As hospitals are attempting to keep expenses down for each diagnosed patient, physicians are operating under competing incentives. The physicians are responsible for diagnosing patients, ordering tests, and performing the medical procedures.⁸⁸ Furthermore, physicians are reimbursed a set fee for each procedure performed and are under a perpetual threat of malpractice litigation should he/she negligently fail to perform a procedure or test.⁸⁹ Therefore, when in doubt, the physician has an incentive to perform the extra test or procedure. This incentive is clearly opposite the hospital's incentive to keep expenses down. As hospitals want to treat the patient with minimal resources and send him home, physicians want to treat the patient as effectively and completely as possible.⁹⁰ Hospitals

85. David M. Frankford, *The Complexity of Medicare's Hospital Reimbursement System: Paradoxes of Averaging*, 78 IOWA L. REV. 517, 572 (1993).

86. *Id.*

87. Fred Bayles & Daniel Q. Haney, *Doctors Feel Pressure to Keep Their Hospitals Financially Healthy*, L.A. TIMES, Nov. 4, 1990, at 26. For example: a patient is admitted with chest pains which the physician thinks it is a heart condition. The physician runs a series of tests and x-rays and concludes it was only indigestion. The tests and x-rays were costly to the hospital. With the DRG system, the hospital will only receive one payment — the payment for treating indigestion. Even though the hospital incurred more expenses in the actual treatment, it still receives the one amount. Therefore, by minimizing expenses, the hospital would be able to make a larger profit from each DRG payment.

88. *See id.* at 26 ("DRGs encourage the hospital to keep their costs down, and yet the physician controls what the hospital bill will be.").

89. *See* Schessler, *supra* note 84, at 379 (stating part of the increase in health care costs is due to the retrospective nature of physician reimbursement and the practice of defensive medicine to avoid malpractice litigation).

90. *See* E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1720 (1987) ("Thus insulated from the economic costs of their

use economic credentialing to force physicians to concentrate on lowering the expense of health care and improving profit margins.⁹¹

2. Economic Credentialing to Avoid Competition

In *Rosenblum v. Tallahassee Memorial Regional Medical Center*,⁹² the only economic credentialing case tried to date, Tallahassee Memorial Regional Medical Center⁹³ ("TMRMC") denied Dr. Rosenblum privileges to its cardiac department solely because he had a contract with a competing hospital, Tallahassee Community Hospital ("TCH").⁹⁴ Because of Dr. Rosenblum's contract with TCH to establish and run its cardiac surgery unit, TMRMC concluded that he would represent a business liability to their hospital.⁹⁵ Although TMRMC admitted that Dr. Rosenblum is a "reputable surgeon with superior skills" and that his qualifications were never an issue,⁹⁶ they denied him privileges.⁹⁷ *Rosenblum* is a clear

decisions and inspired by the societal value that each patient should receive the best health care available, physicians and other providers have had powerful incentives to deliver all indicated care, and virtually no incentives to hold back.").

91. Green, *supra* note 83, at 32. Hospitals who have implemented such programs do not hide the fact that this is strictly an economic plan for the hospital. They believe it is within the "fiduciary responsibility of the board to make sure doctors don't bankrupt the hospital." *Id.* In one situation, a physician was offered \$1.2 million to practice at a hospital based on his profitability to the hospital — not his quality of care or competence. See Steve Sternberg, *Doctor's Hospital Pact Sparks Federal Inquiry: Kennestone Deal Worth \$1.2 Million*, THE ATLANTA CONSTITUTION, Nov. 19, 1992, at 1.

92. No. 91-589 (Cir. Ct. Leon County, Fla. filed June 22, 1992).

93. TMRMC is a 771-bed private, not-for-profit hospital. Howard Larkin, *Judge Upholds Hospital's 'Economic Credentialing'*, AM. MED. NEWS, June 29, 1992, at 5.

94. TCH is a 180-bed private, not-for-profit hospital. *Id.*

95. *Id.* (stating that running a unit at one hospital makes the doctor a business liability at another hospital).

96. *Id.* (the administrator of TMRMC admitted that Dr. Rosenblum's qualifications as a surgeon were not an issue in making credentialing decisions).

97. TMRMC said that it denied Dr. Rosenbaum cardiac privileges in order to protect their cardiac program, since Dr. Rosenblum appeared in advertisements for TCH, might refer uninsured patients to TMRMC, and might recruit nurses from TMRMC's cardiac program. *Id.* The court upheld the economic credentialing decision based on an interpretation of the Florida statute which said "such other elements" may be used in the credentialing process. *Id.* Rosenblum's attorney argued that "the hospital seized on ambiguous language in the law . . . and used it to write a blank check for economic credentialing." *Id.* Although Dr. Rosenblum planned to appeal the decision, the case will not be appealed because he has since been granted cardiac privileges at TMRMC and maintains privileges at both hospitals. *No Appeal in Economic Credentialing Lawsuit*, MANAGED CARE LAW OUTLOOK, Nov. 24, 1992, at 11, 11.

case of a hospital using economic credentialing to avoid competition.

3. Economic Credentialing to Ensure More Profitable Patient Mix

Under economic credentialing, physicians who do not have what the hospital considers a "profitable patient mix"⁹⁸ may be in danger of losing their privileges.⁹⁹ For example, since a hospital is reimbursed for less than its actual expenses for treating Medicaid patients,¹⁰⁰ hospital's tend not to look favorably on physicians with a large Medicaid practice.¹⁰¹ The percentage of Medicaid patients or charity care a physician provides are factors wholly unrelated to competence or quality of care.¹⁰² Therefore, when a hospital decides against privileges to a physician based on patient mix, the hospital is using economic credentialing.¹⁰³

From the above illustrations, it should be clear that economic credentialing arises in different ways. However, in every application, economic credentialing ties a physician's privileges directly to his or her economic performance for the hospital, while ignoring all other criteria. Economic credentialing is receiving increased attention in the 1990's.¹⁰⁴ In some instances,

98. This refers to the proportions of a physician's patients who are private paying, public paying (Medicare & Medicaid), and charity work. For example, a patient mix that is mostly Medicaid patients would be less profitable because of its low reimbursement rates. See Joan Beck, *The Numbers Don't Add Up In Clinton's Health Care Package*, CHI TRIB., Sept. 16, 1993, at N25.

99. Greene, *supra* note 11, at 30.

100. See Lisa Colosi, *Wilder v. Virginia Hospital Association: Making the Medicaid Reimbursement Rate Challenge a Federal Case*, 12 PACE L REV 139, 146 (1992) ("Health care providers nationwide are experiencing financial troubles as a result of inadequate reimbursement rates by state Medicaid agencies.").

101. See *e.g.*, Sternberg, *supra* note 91, at A17 (noting that a "hospital administrator will not look kindly on an obstetrician who has a largely Medicaid practice . . .").

102. Koska, *supra* note 11, at 46.

103. When a hospital decides which physician to court and which to abandon based only on prospective revenue generations for the hospital, the hospital is using economic credentialing. Since a physician's patient mix directly corresponds to the generation of hospital revenue, a decision based on revenue generated is essentially a decision based on patient mix. See, generally, Sternberg, *supra* note 91.

104. A recent national survey, by professor John Blum of Loyola University, shows "that most hospitals use economic criteria when reviewing physicians for medical privileges." Jay Greene, *Economics Widely Used in Reviewing Doctors*, MODERN HEALTHCARE, Nov. 16, 1992, at 10, 10. This survey is part of an ongoing study that is attempting to define the credentialing process and determine how hospitals use credentialing as a disciplinary tool. *Id.*

hospitals are so divided on the issue that physicians are leaving their hospitals.¹⁰⁵ In other instances, state medical societies are taking a stand against such policies.¹⁰⁶ However, the question remains: will hospitals be permitted to exclude or expel physicians based solely on economic considerations?

III. CHALLENGES TO ECONOMIC CREDENTIALING

Society and individual physicians are both directly affected by medical staff peer reviews. As people place themselves in a physician's care with the hope of being cured, they rely on the hospital to ensure a competent and skillful medical staff. Since society has a vested interest in the competency and quality of their treating physicians, hospitals should consider these interests when creating a policy that determines on what criteria a physician will be reviewed for privileges. In addition, if the hospital policy violates the medical staff bylaws (considered a contract between the physician and the hospital) or the federal antitrust laws (prohibiting unfair competition), legal challenges may be brought to invalidate such policies.

Since hospitals that use economic credentialing are not concerned with quality or competence issues, such a policy should be considered against public policy. Furthermore, unless economic criteria is provided in the bylaws as a possible sole criteria for evaluating physicians, economic credentialing would constitute a breach of contract by the hospital. Finally, since economic credentialing is not protected from antitrust scrutiny, such a policy may violate the federal antitrust laws.

A. The Public Policy Challenge

Imagine this: You are sitting in a hospital waiting room, before undergoing a major surgical operation, reading the latest edition of *Newsweek*. While flipping through the magazine,

105. See, e.g., *Proposed Changes in Bylaws Upset Hospital's Medical Staff*, MODERN HEALTHCARE, Aug. 10, 1992 at 18, 18 ("Dennis Cavanaugh, M.D., a 43-year-old surgeon, said he won't practice at Huron Regional because 'the hospital is going in a direction I cannot go.'").

106. See, e.g., *This Week in Healthcare: For The Record*, MODERN HEALTHCARE, October 19, 1992, at 14 (stating that the Medical Society of the State of New York and the California Medical Association have both issued formal policies opposing economic credentialing).

you courageously scan an article regarding hospital care. In the article, a physician is quoted as saying, "[y]ou learn the tricks, learn the shortcuts, then hope you don't do anything wrong."¹⁰⁷ Reading further, you learn that this physician has been told that unless he becomes more profitable to the hospital, he will lose his admitting privileges.¹⁰⁸

With the rising costs of health care, hospitals are in a situation where, in adopting policies, they must balance their private management objectives with those of public interest.¹⁰⁹ In order for a hospital to maintain a policy that furthers its management objectives, the policy also should further the public's interests and certainly not interfere with that interest.¹¹⁰ However, if a policy does not further any public health care objective, or unreasonably interferes with legitimate public health care objectives, such a policy should be invalidated as against the public good.

1. Hospital Policy For a Public Health Care Objective

Hospitals are responsible for operating for the good of the public — not in their own private best interests.¹¹¹ In light of this premise, the reasonableness of hospital policy should be based on how the public health may be affected by the particular policy.¹¹² For example, in *Redding v. St. Francis Medical*

107. Larry Reibstein & Mary Hager, *Physicians Cut Their Costs: Hospitals Get Tough — But How Far Should They Go?*, NEWSWEEK, Dec. 23, 1991 at 41.

108. *Id.* (reviewing the battle between hospitals and doctors over economic credentialing and its consequences).

109. See *Berman v. Valley Hosp.*, 510 A.2d 673, 677 (N.J. 1986) ("Nevertheless, because its exercise implicates the public welfare, as well as individual interests, this kind of managerial discretion is not unbounded.").

110. See *Desai v. St. Barnabas Med. Ctr.*, 510 A.2d 662, 671 (N.J. 1986) (stating that a hospital decision "predicated upon exclusionary policies fostering only the well-being of those staff members who are already admitted [to the hospital staff] . . . must be invalidated").

111. See, e.g., *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 825 (N.J. Sup. Ct. 1963) ("Hospital officials . . . must never lose sight of the fact that the hospitals are operated not for private ends but for the benefit of the public . . ."); *Belmar v. Cipolla*, 475 A.2d 533, 538 (N.J. 1984) ("No matter what arrangement a hospital may have with doctors, its primary purpose remains to serve the public."); *Doe v. Bridgeton Hosp. Ass'n*, 366 A.2d 641, 646 (N.J. 1976), *cert. denied*, 433 U.S. 914 (1977) (stating that reasonable hospital decisions should be respected as long as they are consistent with the public interest); *Berman*, 510 A.2d at 676 ("[The hospital's] health care powers are deeply impressed with a public interest." (quoting *Desai*, 510 A.2d at 668)).

112. See *Desai*, 510 A.2d at 665 (recognizing that the concern for the public interest is significant in determining the reasonableness of hospital decisions).

Center,¹¹³ the California Court of Appeals affirmed the trial court's finding that the hospital's decision to maintain a closed-staff policy was in the interest of "improving patient care, and . . . reducing mortality rates."¹¹⁴ In that case, the court determined that the hospital policy decision was reasonable, even though it prevented independent physicians from acquiring privileges, because it furthered the public health care objectives of improving patient care and reducing mortality rates.¹¹⁵

However, in *Desai v. St. Barnabas Medical Center*,¹¹⁶ the New Jersey Supreme Court in determining the reasonableness of hospital policy reached the opposite conclusion. In *Desai*, the hospital adopted a closed-staff policy of issuing privileges to applying physicians.¹¹⁷ The policy, however, had six exceptions — most importantly allowing privileges to an applying physician who was "joining the medical practice of a current member of the hospital medical staff."¹¹⁸ The court recognized that such a discriminatory policy only could be upheld if it advanced a public health objective.¹¹⁹ The court concluded that since it only benefitted those staff members who already were admitted and was not in furtherance of the public interest, the exception was unreasonable.¹²⁰

When making staffing decisions, the hospital must consider not only public health objectives, but also the interests of the hospital management. Hospitals are given great discretion in their decisions, but only "to the extent that they exert their efforts toward the elevation of hospital standards and higher medical care."¹²¹ Therefore, in assessing hospital expenses and quality-of-care concerns, hospitals always should remember

113. 255 Cal. Rptr. 806 (Cal. Ct. App. 1989).

114. *Id.* at 810-11 (agreeing with the trial court's attachment of "great importance to the public policy considerations involved, the societal, public interest in the best possible medical care").

115. *Id.* at 810.

116. 510 A.2d 662 (N.J. 1986).

117. *Id.* at 664.

118. *Id.* at 664 & n.1.

119. *Id.* at 668. Public health objectives include patient's needs, a reasonable opportunity to select physicians, and adequate access to hospital facilities. *Id.*

120. *Id.* at 671-72. The court stated that this exception not only discriminated against physicians, it also limited access of health care to the patients. *Id.* at 670. See also *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 820 (N.J. Sup. Ct. 1963) (concluding that a hospital's policy which restricted a patient's ability to select the desired physician-hospital combination was not acting reasonably for the public good).

121. *Id.* at 825.

that "their existence is for the purpose of faithfully furnishing facilities to the members of the medical profession in aid of their service to the public."¹²²

Hospitals have grappled with creating reasonable credentialing policies that further both the interests of the public and the interests of hospital management.¹²³ Since credentialing policies have such a broad impact on the public welfare, hospitals should be required to adequately support the reasonableness of their policy.¹²⁴ Hospitals should support such policies with information that "adequately demonstrates that a genuine health care objective is reasonably and rationally served" by the policy.¹²⁵ Without "persuasive information" proving that the hospital needs such a policy to improve patient care, such a policy should not be said to reasonably and rationally advance a legitimate health care objective.¹²⁶

2. Economic Credentialing As Hospital Policy

Since economic credentialing is a form of hospital policy, to be considered reasonable it also should further a legitimate health care objective necessary to improve the quality of care.¹²⁷ However, since economic credentialing "defin[es] an individual's qualification . . . based on economic factors unrelated to quality-of-care or competency considerations,"¹²⁸ such

122. *Id.*

123. *See, e.g.,* *Berman v. Valley Hosp.*, 510 A.2d 673, 676 (N.J. 1986) ("In determining the validity of a managerial decision made by a hospital, courts understand that the major concern is whether the public interest in health care is reasonably and rationally advanced by the hospital's decision.").

124. In *Berman*, the New Jersey Supreme Court stated that the reasonableness of a hospital's physician credentialing policy will be reviewed by "consider[ing] the nature and adequacy of the information that has been advanced in its support" because such a policy "implicates the public welfare." *Id.* at 677. The court further explained that "a hospital decision of this character will be viewed favorably if it is reached in the normal and regular course of conducting the affairs of the hospital, and is based on adequate information, regardless of form, origin, or authorship, that is generally considered reasonable and reliable by professional persons responsibly involved in the health care field." *Id.* (quoting *Desai v. St. Barnabas Med. Ctr.*, 510 A.2d 662, 669 (N.J. 1986)).

125. *Id.* at 677. In *Berman*, the health care objective was reducing and controlling hospital overcrowding and excessive patient-bed occupancy. *Id.* The court stated that the evidence did not demonstrate that the hospital's credentialing policy sufficiently related to that health care objective. *Id.* at 680.

126. *Id.* at 680. The court went on to say that it expected the plaintiffs to be granted full staff privileges, absent any valid grounds for denial. *Id.*

127. *Id.*

128. *Lang, supra* note 11, at 28.

a policy should not be considered reasonably and rationally in furtherance of a legitimate health care objective. With economic credentialing, hospitals place the interests of managing the hospital before the interests of the public — usually not even considering the interests of the public.¹²⁹ Such a policy not only has no legitimate public health care objective, it also unreasonably interferes with several legitimate health care objectives.

Access to Health Care: Most importantly, economic credentialing interferes with the public's access to health care. Since physicians only may treat patients in hospitals where they have privileges, denying privileges effectively denies patients access to health care. For example, a hospital may not look favorably upon a physician who has a large Medicaid practice, since Medicaid typically reimburses the hospital less than Medicare or privately insured patients.¹³⁰ If that hospital maintains a policy of economic credentialing, it would be able to revoke that physician's privileges, forcing his/her patients to obtain health care elsewhere. This may not be a problem if the physician has privileges in another nearby hospital; however, if the physician has privileges in a far away hospital or in no other hospital at all, these patients will be denied the ability to select their desired physician-hospital combination.¹³¹ Denial of such access

129. See *supra* notes 92-97 and accompanying text. For instance, an emergency room surgeon on duty decided that his emergency room would be overwhelmed by attempting to care for all the victims of a car wreck. Bayles & Haney, *supra* note 87, at 26. He ordered the ambulances to take the victims to three other hospitals, aside from his own, so they would receive care more quickly; however, since less victims were treated at his hospital the result was less business for the hospital. *Id.* The hospital told him never to do that again. *Id.* See also *id.* (keeping hospital costs down may require patients to be treated in a non-individualized manner); Sternberg, *supra* note 91, at A17 (in which a hospital attempted to jettison the chief of the pulmonary department — who netted the hospital less revenue — in order to recruit a physician who later became one of the hospital's "Top Five revenue generators").

130. See *supra* notes 98-103 and accompanying text.

131. See Greene, *supra* note 11, at 30 ("[E]conomic credentialing can lead to poor patient care by limiting services, reducing access to care and interfering with the physician-patient relationship.").

would not be considered acting for the public good.¹³²

A policy restricting access might be considered reasonable if it furthers quality or competency concerns;¹³³ however, economic credentialing removes these issues from consideration, effectively eliminating any inference of reasonableness. Since economic credentialing would allow a hospital to exclude a physician without any legitimate health care reason while limiting patients' access to health care, such a policy unreasonably would interfere with the public health care objective of access to health care.

Higher Quality Health Care: Economic credentialing also interferes with the public health care objective of higher quality health care. Indeed, one of the main goals of the HCQIA was to increase the quality of health care by effectively removing incompetent physicians who provided a low level of care.¹³⁴ Congress was so concerned about removing incompetent physicians that it legally protected good-faith peer reviews which were based on competence or quality concerns.¹³⁵ However, under economic credentialing, the focus of credentialing turns away from quality and competence, to concerns of economics and profits. Congress specifically refrained from extending legal protection to peer reviews that were not based on quality or competence concerns because "such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls."¹³⁶ Thus, Congress determined that protecting such credentialing would interfere unreasonably with the public objective of higher quality health care. Since economic credentialing, by definition, is devoid of quality

132. See *Desai v. St. Barnabus Med. Ctr.*, 510 A.2d 662, 666 (N.J. 1986) ("In determining that the hospital's actions were not exercised reasonably for the public good, the Court emphasized that the hospital's policy restricted the patient's ability to select the desired doctor-hospital combination. (citing *Geisman v. Newcomb Hosp.*, 192 A.2d 817 (N.J. 1963)).

133. See *supra* notes 113-115 and accompanying text.

134. See *supra* notes 55-65 and accompanying text.

135. See *supra* notes 55-65 and accompanying text.

136. Scott, *supra* note 58, at 331 n.62.

or competence concerns, such a policy unreasonably interferes with this public health care objective.

Reduce Malpractice and Health Care Costs: Finally, in adopting an economic credentialing policy, hospitals unreasonably interfere with the public health care objective of reducing malpractice and health care costs.¹³⁷ As already discussed, hospitals have an incentive to minimize resources and expenses for each admitted patient.¹³⁸ Physicians, on the other hand, have an incentive to provide the best and most complete care possible to cure their patients and avoid malpractice.¹³⁹ Under a policy of economic credentialing, physicians will be forced to find shortcuts to keep their costs down in order to retain their hospital privileges.¹⁴⁰ However, if physicians become more concerned with the cost of an additional test rather than the potential good the test may do for the patient,¹⁴¹ clearly the quality of care would decline, increasing the likelihood of malpractice litigation and the overall cost of health care.¹⁴² As the public has legitimate health care objectives to increase the quality of care while reducing malpractice litigation and the overall cost of health care, a policy of economic credentialing unreasonably interferes with these objectives.

Although hospitals may have a rationale for implementing economic credentialing policies, such policies simply do not further any public health care objective. And while hospitals may be given great deference in adopting their policies, such discretion is not boundless.¹⁴³ Unless the hospital's policy is reasonably and rationally in furtherance of a public health care objective, the policy should be held invalid as being against the public good.¹⁴⁴ Since economic credentialing not only does not

137. This public health care objective arises from Congress' intent under HCQIA to encourage good-faith peer review in order to rid hospitals of incompetent physicians. See *supra* notes 55-65 and accompanying text.

138. See *supra* notes 85-91 and accompanying text.

139. See *supra* notes 85-91 and accompanying text.

140. See Reibstein & Hager, *supra* note 107, at 41 (noting that some doctors fear that economic credentialing will lead to lack of health care for the elderly and indigent).

141. For example, the extra test may reveal an unforeseen problem. This test, therefore, enhances the quality of care provided while eliminating any malpractice suits.

142. See Schessler, *supra* note 84, at 381 (stating that the current rise in health care costs is in part due to an increase in malpractice liability).

143. *Berman v. Valley Hosp.*, 510 A.2d 673, 677 (N.J. 1986).

144. See *supra* notes 111-26 and accompanying text.

further the public interest but also unreasonably interferes with legitimate public health care objectives, such a policy should be held invalid as being against the public good.

B. The Breach of Bylaws Challenge

As mandated by JCAHO and many state statutes, the rules for the peer review process must be incorporated into the medical staff bylaws.¹⁴⁵ Therefore, when a physician receives an adverse peer review decision, he or she may attempt to challenge the decision as not following the rules set up in the bylaws.¹⁴⁶ The issues then become the extent of the legal significance of the medical staff bylaws and upon what grounds a physician can substantiate a challenge.

Of all the challenges brought by physicians against peer review decisions, breach of bylaws has been recognized most widely as a challenge that will overturn a peer review decision because the courts and JCAHO have determined that medical staff bylaws constitute a binding contract between the hospital and the medical staff physicians.¹⁴⁷ For example, in *Spencer v. Community Hospital of Evanston*,¹⁴⁸ the court stated that when a physician's privileges are revoked or reduced the hospital must follow its bylaws in the decision-making process.¹⁴⁹ And more recently, in *Alfredson v. Lewisburg Community Hospital*,¹⁵⁰ the court indicated that the medical staff bylaws must be followed as "a hospital's bylaws are an integral part of its contractual relationship with the members of its medical staff."¹⁵¹ Furthermore, some courts have ruled that, in addition

145. See *supra* note 79 and accompanying text.

146. Blum, *supra* note 16, at 438.

147. See, e.g., *Miller v. Indian Hosp.*, 419 A.2d 1191, 1193 (Pa. Super. Ct. 1980) (hospital bylaws are binding contracts between a health care provider and the hospital); *Bhatnagar v. Mid-Maine Med. Ctr.*, 510 A.2d 233, 234 (Me. 1986) (stating that hospital bylaws "constitute an enforceable contract between [the physician] and [the hospital]").

148. 408 N.E.2d 981 (Ill. App. 1980).

149. *Id.* at 984 (quoting *Jain v. Northwest Community Hosp.*, 385 N.E.2d 108, 112 (Ill. App. 1978)).

150. No. 88-311-II, 1989 WL 134739 (Tenn. App. Nov. 8, 1989), *rev'd in part on other grounds*, *Lewisburg Community Hosp. v. Alfredson*, 805 S.W.2d 756 (Tenn. 1991).

151. *Id.* at 7 (citing *Pariser v. Christian Health Care Sys., Inc.*, 816 F.2d 1248, 1251 (8th Cir. 1987); *Adler v. Montefiore Hosp. Ass'n*, 311 A.2d 634, 645 (Pa. 1973), *cert. denied*, 411 U.S. 1131 (1974)).

to creating a contractual obligation, hospital bylaws must be followed as a matter of public policy.¹⁵²

As discussed above, JCAHO specifically mandates that hospitals have bylaws that incorporate the rules of self governance and that those bylaws are a binding contract that neither party unilaterally may amend.¹⁵³ Therefore, JCAHO is consistent with the courts' decisions that hospital bylaws must be upheld as legally binding contracts that cannot be altered unilaterally. Since these bylaws are considered a binding contract between the physicians and the hospital and required to include the rules for credentialing, a violation of the rules would lead to a breach of contract claim. Therefore, in order to avoid a breach of contract suit, these credentialing rules must be followed.

Since its inception, peer review credentialing has been used as a mechanism to keep out incompetent and poor quality physicians.¹⁵⁴ However, as hospitals are now considering the use of economic criteria in the decision-making process, the bylaws must be inspected to find approval for the use of such criteria. Since current bylaws reflect the original intent of the peer review process (that is quality and competence concerns), finding such approval in the bylaws may prove difficult. It would be especially difficult to find approval for basing a credentialing decision solely upon economic criteria while ignoring all quality and competence concerns. In order to receive such approval, medical staff bylaws would have to be amended to include economic criteria. A special provision must be implemented into the bylaws to uphold a decision based solely upon economic considerations. Would a hospital attempt to unilaterally amend the bylaws? If it did, it would not only run up against an array of legal precedent but also the JCAHO regu-

152. See *Balkissoon v. Capitol Hill Hosp.*, 558 A.2d 304, 308 (App. D.C. 1989) ("The Hospital's obligation to follow its bylaws does not arise only from a contractual relationship with [the physician] . . . [t]he public has a substantial interest . . ."). In *Balkissoon*, the court decided that the hospital was obligated to follow its bylaws due to the public's interest in effectively operated hospitals. *Id.* The court believed that the public had an interest in seeing that hospitals follow their bylaws and do not act arbitrarily: "Thus, while sharing the interest of hospitals that only qualified doctors be given staff privileges, the public also has an interest in assuring that staff decisions are not made arbitrarily. A hospital's failure to comply with material procedures delineated in its bylaws is inherently arbitrary." *Id.*

153. See *supra* notes 2, 80 and accompanying text.

154. See *supra* notes 33-43 and accompanying text.

lations that specifically forbid such an act. Since medical staff bylaws cannot be unilaterally amended, such an alteration would require not only the approval of the governing board, but the approval of the medical staff as well. However, attempting to convince a medical staff to agree with such amendments will be an arduous task. "Attempts by hospitals to impose a system of economic credentialing will cause enormous stresses and strains on an already tenuous relationship between medical staffs and hospital boards."¹⁵⁵ Physicians will not approve of amending hospital bylaws to provide for economic credentialing because such factors are not in the best interest of their patients or themselves.¹⁵⁶ If the medical staff will not support such amendments, economic credentialing will be prevented from being introduced to hospital bylaws, effectively providing physicians with a legal challenge to any such decision.

However, some courts may interpret a hospital's bylaws as already allowing economic credentialing with such phrases as "in pursuit of institutional objectives" or "any other relevant factors." Even though these phrases allow the use of economic factors in the decisionmaking process, they really amount to the permissible use of utilization review.¹⁵⁷ Since economic credentialing is distinct from utilization review,¹⁵⁸ such inclusive language in hospital bylaws will not permit the exclusive use of economic criteria in the peer-review process. Without a specific provision in the medical staff bylaws allowing for the use of economic credentialing, such a policy will constitute a breach of the hospital's contractual obligation.

155. Lang, *supra* note 11, at 28.

156. See *supra* notes 88-91 and accompanying text (focusing on physicians' disincentive to hold back on health care).

157. See Greene, *supra* note 11 at 30. This is because these phrases commonly are written to add to quality and competency factors already required in the credentialing decision. For example: "Physicians will be reviewed on quality and competency criteria *and* any other relevant factors," the "and" implies "in addition to" — still not allowing economic credentialing. If the bylaws read: "quality and competency criteria *or* economic criteria," the "or" would imply the ability to use exclusively economic criteria.

158. See Greene, *supra* note 11 (discussing the differences between utilization review and economic credentialing).

C. The Antitrust Challenge

Federal antitrust laws are considered "fully applicable in the context of the health care industry."¹⁵⁹ Therefore, with the possibility of treble damages, federal antitrust challenges have "posed the biggest threat" of all the challenges brought by physicians in peer review litigation.¹⁶⁰

Although sometimes with considerable skepticism,¹⁶¹ the courts have continued to entertain antitrust challenges to peer review decisions because "[a]buse of the peer-review process is not just hypothetically possible but has been found to have occurred in a small but significant number of cases."¹⁶²

The goal of the federal antitrust laws is to preserve competition in the marketplace by forbidding certain anti-competitive conduct. In particular, Section 1 of the Sherman Act¹⁶³ renders unlawful "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade."¹⁶⁴ Since by definition, peer review activity involves a form of concerted activity, peer review decisions have great potential for antitrust vio-

159. Blumstein & Sloan, *supra* note 31, at 39 & n.222.

160. Scott, *supra* note 58, at 332.

161. See Scott, *supra* note 58, at 335 ("This sentiment is perhaps founded on a lurking judicial suspicion that many, if not most, such cases are illegitimate . . ."); Blumstein & Sloan, *supra* note 31, at 37 ("As plaintiffs have sought to have antitrust doctrine applied to hospital peer-review activity, it has become clear that courts have, in general, been very wary of what they perceive to be a questionable, if not illicit, relationship.").

162. Scott, *supra* note 58, at 336. See, e.g., *Patrick v. Burget*, 486 U.S. 94 (1988), *reh'g denied*, 487 U.S. 1243 (1988) (holding that the medical staff violated §§ 1 and 2 of the Sherman Act by participating in peer reviews in order to reduce competition); *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440 (9th Cir. 1988) (finding that a nurse was harmed by conspiracy of anesthesia service providers that was designed to eliminate competition).

163. Section 1 states:

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding \$10,000,000 if a corporation, or, if any other person, \$350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

15 U.S.C.S. § 1 (Law. Co-op. 1994).

164. *Id.* Section 1 does not apply to independent action. "An economic entity 'generally has a right to deal, or refuse to deal, with whomever it likes, as long as it does so independently.'" Blumstein & Sloan, *supra* note 31, at 25 (quoting *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 761 (1984)).

lations.¹⁶⁵ In order to prevail in a Section 1 action against peer review activity, three elements must be proven. First, the physician must prove the peer review affects interstate commerce. Second, the physician must prove the peer review decision was made by a contract, combination or conspiracy. Finally, the physician must prove the peer review decision produced an adverse and anticompetitive effect on competition.

1. Affecting Interstate Commerce

To analyze a peer review decision under the Sherman Act, it must first be determined whether or not the conduct (the peer-review activity) is in or substantially affects interstate commerce.¹⁶⁶ This had been seen as a jurisdictional "stumbling block" to physicians who could not show that the peer review decision had such an effect.¹⁶⁷ To get over this jurisdictional hump, the physician had to identify, with evidence beyond the pleadings, the relevant part of interstate commerce affected.¹⁶⁸

However, in *Summit Health, Ltd. v. Pinhas*,¹⁶⁹ the Supreme Court made this jurisdictional requirement easier to meet. In *Pinhas*, an ophthalmologist with privileges in a Los Angeles hospital alleged a conspiracy between the hospital and its staff to revoke his hospital privileges.¹⁷⁰ In alleging a violation of Section 1 of the Sherman Act, Dr. Pinhas asserted that excluding his services from the hospital had the required effect on interstate commerce to give the court federal jurisdiction.¹⁷¹ The Court held that since ophthalmological services are "regularly performed for out-of-state patients and generate revenues from out-of-state sources,"¹⁷² their exclusion would have "a sufficient nexus with interstate commerce to support federal jurisdiction."¹⁷³ Since almost all hospital physicians treat out-of-

165. Blumstein & Sloan, *supra* note 31, at 25. See also Scott, *supra* note 58, at 336 ("The denial or termination of medical staff privileges necessarily has the effect of eliminating a competitor and thus . . . raise[s] antitrust concerns.").

166. See *McLain v. Real Estate Bd.*, 444 U.S. 232, 242 (1980).

167. Blumstein & Sloan, *supra* note 31, at 25 n.85 (citing *McLain v. Real Estate Bd.*, 444 U.S. 232, 241 (1980)).

168. *McLain*, 444 U.S. at 242.

169. 111 S. Ct. 1842 (1991).

170. *Id.* at 1844.

171. *Id.*

172. *Id.* at 1847.

173. *Id.* at 1849. The Court stated that although only one physician was excluded, there was still federal jurisdiction:

state patients and receive out-of-state revenue, the *Pinhas* decision effectively allows physicians excluded from health care entities as a result of the peer-review process to almost always satisfy the jurisdictional requirement of affecting interstate commerce.¹⁷⁴

2. Contract, Combination or Conspiracy

Since Section 1 of the Sherman Act does not wholly forbid unilateral conduct, the physician must prove that two or more distinct entities agreed to take action against him.¹⁷⁵ However, officers or employees of corporations or divisions of corporations do not provide this required plurality.¹⁷⁶ Therefore, in order for a physician to successfully sustain a Section 1 challenge against an adverse peer-review decision, it must be determined that the medical staff has the capacity to perform such a concerted activity.

The prevailing rule is established in *Weiss v. York Hospital*.¹⁷⁷ In *Weiss*, the court described the medical staff as:

[a] group of doctors, all of whom practice medicine in their individual capacities, and each of whom is an independent economic entity in competition with other doctors in the . . . medical community. Each staff member, therefore, has an economic interest separate from and in many cases in competition with the interests of other medical staff members. Under

[B]ecause the essence of any violation of § 1 is the illegal agreement itself — rather than the overt acts performed in furtherance of it — proper analysis focuses, not upon actual consequences, but rather upon the potential harm that would ensue if the conspiracy were successful Thus, respondent need not allege, or prove, an actual effect on interstate commerce to support federal jurisdiction.

Id. at 1847-48.

174. See Gale T. Miller, *Antitrust Developments in 1990-91: U.S. Supreme Court Decisions*, 21 COLO. LAW. 235 (1992) ("The U.S. Supreme Court's decision [in *Pinhas*] . . . makes it difficult to envision many health care cases that could not be reached by the federal antitrust laws."); Diane Ruder, *Antitrust and the Credentialing and Decredentialing of Physicians*, 19 N. KY. L. REV. 351, 353 (1992) (after *Pinhas*, "the common disputes over denial of hospital staff privileges have become issues with a federal forum"); Einer Elhauge, *Making Sense of Antitrust Petitioning Immunity*, 80 CAL. L. REV. 1177, 1196 n.105 (1992) (stating that "because the interstate commerce requirement is so weak, as a practical matter it excludes very few restraints").

175. See *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 768 (1984) (holding that, in order to find a § 1 violation, there must be concerted activity).

176. *Id.* at 770-71.

177. 745 F.2d 786, 816 (3d Cir. 1984) (holding that "a single entity made up of independent competing economic entities satisfies the joint action requirement of Sherman Act Section 1").

these circumstances, the medical staff cannot be considered a single economic entity for the purposes of antitrust analysis.¹⁷⁸

Therefore, the *Weiss* court concluded that the medical staff's actions (which would include peer review decisions) should be viewed as "actions of a combination of the individual doctors who make it up."¹⁷⁹ As *Weiss* and other courts have noted,¹⁸⁰ the medical staff of a hospital has the capacity to conspire amongst itself, therefore, creating a concerted activity susceptible to antitrust scrutiny. Furthermore, by definition, a peer review is a collective decision of the medical staff members on the peer review committee. Therefore, every peer review decision of the hospital medical staff has the potential for an antitrust violation.

3. Producing Adverse and Anti-Competitive Effects

Once the physician has proven a conspiracy among the medical staff, it must be further proven that the concerted action caused an unreasonable restraint of trade.¹⁸¹ Although all commercial agreements may be said to somewhat restrain trade, only unreasonable restraints violate Section 1.¹⁸² Judging the reasonableness of the restraint depends upon "its impact on competition as a whole within the relevant market."¹⁸³ The courts have used two approaches in assessing the reasonableness of such restraints: *illegal per se* and *the rule of reason*.

Illegal Per Se: A court will hold conduct illegal per se when the concerted activity has a "pernicious effect on competition and lack[s] . . . any redeeming virtue."¹⁸⁴ Such agreements

178. *Id.* at 815.

179. *Id.* at 816.

180. *See, e.g., Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 706 (4th Cir. 1991) ("[W]hen these actors [the physicians of the medical staff] join together to take action among themselves, they are unlike a single entity and therefore they have the capacity to conspire as a matter of law.").

181. *Id.* at 708.

182. *See Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing, Co.*, 472 U.S. 284, 289 (1985) (stating that, although the "decision of the cooperative members to expel Pacific was certainly a restraint of trade in the sense that every commercial agreement restrains trade . . . , whether this action violates § 1 of the Sherman Act depends on whether it is adjudged an unreasonable restraint.").

183. *Oksanen*, 945 F.2d at 708.

184. *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 5 (1958).

are said to be so manifestly anticompetitive in nature that they can be deemed illegal without close evaluation.¹⁸⁵ However, the lines between the per sé rule and the rule of reason have been blurred as courts have overruled previous per sé cases and refused to expand the categories of cases subject to the per sé analysis.¹⁸⁶ Furthermore, courts have "been slow to condemn rules adopted by professional associations as unreasonable per sé."¹⁸⁷

Rule of Reason: Under the rule of reason analysis, the test of legality is "whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition."¹⁸⁸ This entails an analysis of "the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed."¹⁸⁹ Furthermore, the restraint must be proven to have the potential to produce "adverse, anticompetitive effects within relevant product and geographical markets."¹⁹⁰

Which Approach to Use? Under the per sé rule, "anticompetitive purpose[s] and anticompetitive effect are conclusively presumed to exist once the forbidden conduct is proven, so that proof of the forbidden conduct is by itself proof of an antitrust

185. *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440, 1445 & n.1. (9th Cir. 1988) (examples of such agreements are boycotts, concerted refusals to deal and price fixing).

186. *Blumstein & Sloan, supra* note 31, at 54. *See, e.g., FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 458 (1986) ("Although this Court has in the past stated that group boycotts are unlawful per sé . . . the category of restraints classed as group boycotts is not to be expanded indiscriminately, and the per sé approach has generally been limited"); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 9-14 (1984) (holding that, although tying arrangements were traditionally deemed per sé illegal, they are only per sé illegal if the seller has the ability "to force a purchaser to do something that he would not do in a competitive market").

187. *Indiana Fed'n of Dentists*, 476 U.S. at 458.

188. *Id.* (quoting *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918)).

189. *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 692 (1978).

190. *Davis-Watkins Co. v. Service Merchandise*, 686 F.2d 1190, 1195 (6th Cir. 1982), *cert. denied*, 466 U.S. 931 (1984). Commodities that are reasonably interchangeable by consumers for the same purposes are considered within the relevant product. *United States v. Du Pont*, 351 U.S. 377, 395 (1956). The area in which a potential buyer rationally may look for the goods and services he seeks is considered within the relevant geographical area. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966).

violation.”¹⁹¹ Such an approach would be inappropriate in evaluating peer review decisions. The conduct being analyzed in credentialing cases is the peer review decision of the medical staff. Under the per sé rule, every challenged peer review decision would have to be held invalid because that conduct would be considered “unlawful in and of itself, without regard to the effect of the conduct or the purpose of those engaging in it.”¹⁹² Since the peer review process is not so “inherently anticompetitive” this approach would not be appropriate for determining anticompetitiveness.¹⁹³

Since the per sé rule is inappropriate in evaluating the anticompetitiveness of peer reviews, a rule of reason approach should be used. The rule of reason approach is better suited to this evaluation because under this rule, “the anticompetitive purpose or effect of the conduct” must be proven.¹⁹⁴ Since a peer review very often has no anticompetitive purpose, this case by case approach will eliminate more accurately only the anticompetitive peer reviews.¹⁹⁵ Therefore, in order for a physician to prove that an adverse peer review decision violated Section 1, he must prove that the decision unreasonably restrained trade by having an anticompetitive effect within the relevant market.¹⁹⁶

191. Peter M. Gerhart, *The Supreme Court and Antitrust Analysis: The (Near) Triumph of the Chicago School*, in *THE SUPREME COURT REVIEW* 319, 322 (Philip B. Kurland et al. eds., 1982).

192. *Id.*

193. Peer reviews hardly can be seen as inherently anticompetitive in and of themselves as they are mandated by JCAHO, hospital bylaws, state statutes and protected by the HCQIA to further quality and competence concerns. See *supra* notes 47-80 and accompanying text.

194. Gerhart, *supra* note 191, at 322 (citing *Standard Oil Co. v. United States*, 221 U.S. 1 (1911)).

195. Courts have applied such an analysis to challenges of peer review decisions. See *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 708-09 (4th Cir. 1991) (where the court used the rule of reason approach to evaluate a physician's § 1 claim against the medical staff for revoking his privileges).

196. If the peer review decision has legitimate procompetitive value, it will not be considered an antitrust violation. See *Health Care Lawyers Probe Antitrust Law Developments*, 58 ANTITRUST AND TRADE REGULATION REPORT, Feb. 22, 1990, at 268 (including the following procompetitive reasons: inadequate skill, experience, failure to carry malpractice insurance, disruptive personality and unwillingness to take staff member responsibilities). Furthermore, the peer review may be immune from antitrust litigation. See *infra* notes 205-14 and accompanying text.

As mentioned above, Section 1 violations have been proven in several cases.¹⁹⁷ The Supreme Court in *Patrick v. Burget*¹⁹⁸ affirmed the circuit court's decision that Oregon physicians violated the Sherman Act when they improperly participated in peer review activity, resulting in the loss of Dr. Patrick's hospital privileges.¹⁹⁹ The events of this case occurred in Astoria, Oregon, a town with a population of 10,000²⁰⁰ and with one hospital and one private clinic.²⁰¹ Patrick, who had privileges in the hospital as a general and vascular surgeon, declined an offer to become a partner in the private clinic and instead set up a private practice to compete with the clinic.²⁰² Physicians of the clinic initiated and participated in a peer review evaluation of Patrick, which resulted in the loss of his privileges at the community's one hospital.²⁰³

Patrick illustrates a classic example of a medical staff unreasonably restraining trade by having an anticompetitive effect within the relevant market. Since there was only one hospital in the area, the relevant market was established.²⁰⁴ Furthermore, since the restraint on trade was contrary to the legitimate purpose of the peer review process and had no procompetitive effects, such evidence was sufficient to determine concerted activity in violation of Section 1.

4. Immunity To Antitrust Liability

The *Patrick* decision also illustrates that the state-action doctrine²⁰⁵ of antitrust immunity will not protect peer review

197. See *supra* note 162.

198. 486 U.S. 94 (1988).

199. *Id.* at 96-98.

200. *Id.* at 95.

201. *Id.* at 96.

202. *Id.*

203. *Id.* at 97.

204. A similar finding occurred in *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440 (9th Cir. 1988). In *Oltz*, a nurse anesthetist was terminated following an exclusive staff agreement between the hospital and the anesthesiologists. *Id.* at 1443. Oltz sued the hospital and anesthesiologists for antitrust violations. *Id.* at 1444. On appeal, the hospital argued that there was no injury to competition because the lower court improperly defined the relevant market. *Id.* at 1445. However, the Ninth Circuit determined that it was "inescapable" to find that the one-hospital town was the relevant market for finding antitrust injury. *Id.* at 1446-47.

205. The state-action doctrine, also known as the Parker defense, arose out of the Supreme Court case *Parker v. Brown*, 317 U.S. 341 (1943). The Court held that the Sherman Act did not intend "to restrain state action or official action directed by a state." *Id.*

activity.²⁰⁶ The Court recognized that "effective peer review is essential to the provision of quality medical care" and the possible "chilling effect" that could fall upon peer review if immunity is not granted.²⁰⁷ However, the Court concluded that unless Congress grants such immunity by law, the only state-action immunity that would be granted is where "the State effectively has made this conduct its own."²⁰⁸

Following *Patrick*, Congress provided limited antitrust immunity for participants in medical staff peer reviews in the Health Care Quality Improvement Act of 1986 ("HCQIA").²⁰⁹ The HCQIA is Congress's way of "accurately and expeditiously distinguishing . . . legitimate peer review activity" (that which is intended to improve the quality of care) from abusive peer review activity.²¹⁰ Therefore, in order to qualify for protection, the peer reviewers must base their decision on "the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients)."²¹¹

In furthering its efforts to protect only good-faith peer reviews, the drafters of the HCQIA specifically stated instances that would not be considered based on competence or professional conduct. This list includes decisions based on whether or not a physician joined a professional society, the fees or advertising of the physician, the economic organization of the medical practice, or the physician's activities with other health care professionals.²¹² Since this list is not intended to be complete,

at 351. This rationale subsequently was applied to private parties whose challenged restraint was "clearly articulated as state policy" and must be "actively supervised by the State itself." *Patrick v. Burget*, 486 U.S. 94, 100 (1988).

206. *Patrick*, 486 U.S. at 105.

207. *Id.*

208. *Id.* at 105-06.

209. 42 U.S.C. §§ 11111-11115 (1988). The immunity is only from damages in an antitrust suit. *Id.* at § 11111(a)(1) The immunity does not apply to a suit for injunctive relief. See Scott, *supra* note 58, at 323 n.24, 332 n.69.

210. Scott, *supra* note 58, at 321. See also *id.* at 330 (stating that "[e]xamples of abuse of the peer review process include adverse peer review decisions made, not because of any incompetence or misconduct on the physicians' part, but because of their race or origin or the race or origin of their patients; because the physicians served poor, uninsured, or underinsured patients; because they posed an economic threat to other physicians; because of some other 'turf battle' among medical specialists; or because they blew the whistle on other colleagues who were incompetent.").

211. 42 U.S.C. § 11151(9) (1988).

212. *Id.* at §11151(9)(A)-(D).

the Act states that immunity is excluded for "any other matter that does not relate to the competence or professional conduct of a physician."²¹³ Therefore, the above provisions conclusively support Congress' intent that medical staff peer review is to be used legitimately to "improve the quality of medical care in this country by encouraging the medical profession to rid itself of bad doctors."²¹⁴

5. Another Obstacle For Economic Credentialing

If an adverse peer review decision were based solely upon economic criteria, a stronger antitrust case may be brought by a disgruntled physician.²¹⁵ First, economic credentialing would not fall under the protection of the HCQIA immunity provisions, because basing a credentialing decision solely upon economic considerations does not relate to the competence or professional conduct of a physician. As noted above, if a physician was affected adversely by a peer review decision because he served poor patients, because he was an economic threat to other physicians or because of some sort of "turf battle," the reviewers would not receive immunity.²¹⁶

Furthermore, from the discussions noted in the Congressional and House Reports, it is evident that this immunity is to be construed narrowly. The main purpose of this immunity is to "improve the quality of medical care in this country by encouraging the medical profession to rid itself of bad doctors."²¹⁷ Therefore, unless the economic criteria was somehow evidence of quality concerns, the protection would not be provided.²¹⁸ Certainly, in a case of economic credentialing, where economics were the sole criteria, such immunity would be inappropriate.

213. *Id.* at § 11151(9)(E).

214. Scott, *supra* note 58, at 318. See also H.R. REP. NO. 903, 99th Cong., 2d Sess. (1986) (a favorable report by Mr. Dingel submitted to the Committee on Energy and Commerce concerning H.R. 5540, 99th Cong., 2d Sess. (1986) which sought to encourage physician peer review).

215. This is assuming the physician could prove that a conspiracy existed. Economic criteria will not make this part of the analysis any stronger, it only strengthens the *unreasonableness* of the restraint.

216. Scott, *supra* note 58, at 330 & n.55-60.

217. *Id.* at 318.

218. If the economic criteria were evidence of some quality concern, this would be a legitimate use of the peer review process. See *supra* note 84 (discussing utilization review).

Since antitrust immunity would not be available for economic credentialing, participants in such peer review decisions would be subject to the federal antitrust laws. As discussed above, challenges to peer reviews are said to have met the jurisdictional requirement.²¹⁹ Furthermore, the hospital medical staff is considered to have the capacity to conspire.²²⁰ Additionally, situations arise where the restraint on trade, via the peer review decision, is within the relevant market.²²¹ Therefore, if the restraint is unreasonable and not pro-competitive, the peer review decision will violate Section 1 of the Sherman Act.

Economic credentialing can be an unreasonable and anti-competitive restraint of trade.²²² Under a rule of reason analysis, the court must consider the reasons why the adverse peer review decision was imposed.²²³ If the reasons are legitimate, that would evidence a reasonable restraint of trade. However, in light of the lengthy discussions revolving around the HCQIA immunity provisions, a peer review based solely on economic considerations may be an inappropriate abuse of the peer review system. In a case such as *Patrick*, where there is only one hospital, such a restraint significantly would reduce competition and might affect drastically the quality and availability of care to the public. The fact that a peer review decision was based solely on economic considerations would be additional evidence that the restraint was unreasonable and anti-competitive. Therefore, economic credentialing may enhance an already plausible antitrust challenge of an adverse peer review decision.²²⁴

219. See *supra* notes 169-74 and accompanying text.

220. See *supra* notes 175-80 and accompanying text.

221. See *supra* note 204 and accompanying text.

222. Courts have held that peer review itself can be viewed as pro-competitive. See, e.g., *Marin v. Citizens Memorial Hosp.*, 700 F. Supp. 354, 361 (S.D. Tex. 1988) ("restricting staff privileges to doctors who maintain a basic level of medical competency is ultimately pro-competitive not anti-competitive"); *Quinn v. Kent Gen. Hosp.*, 617 F. Supp. 1226, 1239 (D.C. Del. 1985) ("[P]eer review process is arguably pro-competitive, for by monitoring the qualifications and performance of physicians it may compensate for the relative lack of information about these matters by consumers."). These cases illustrate that where peer review is used to promote quality of care concerns, it will be considered pro-competitive. Therefore, by excluding quality concerns and focusing solely on economic criteria, the pro-competitive value noted by these courts arguably is lost.

223. *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 692 (1978).

224. Economic credentialing is not necessarily anticompetitive in every instance. If that were the case, it would be possible to consider economic credentialing as being inher-

IV. CONCLUSION

The main goal of the peer review process is to provide patients with top quality care by competent physicians. As introduced by the common law of hospital corporate liability and further supported by JCAHO, as inscribed in hospital bylaws and as protected by the HCQIA, the peer review system effectively functions to rid the medical field of incompetent physicians. As stated in such laws and policies, peer review decisions are to be evaluated based on competence and quality concerns.

Economic credentialing substitutes economic criteria for the required quality concerns. The result is that a physician may be denied privileges or have existing privileges revoked based solely upon economic criteria regardless of the physician's competency and regardless of the impact on society. Such peer review decisions do not serve the public's interest and run afoul of statutory law, common law and hospital bylaws. Notwithstanding the hospital's concern for its bottom line, society cannot tolerate the effects of economic credentialing. Hospitals always must remember that they exist to serve the public's interest, not their own private interests.

Brad Dallet†

ently anticompetitive and a per se violation. However, since it may be possible that economic credentialing may occur while not being anticompetitive, the sole use of economic criteria in the peer review process should provide additional support to an existing claim of an antitrust violation.

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